North Dakota
Real Choice Systems Change Grant
Rebalancing Initiative

Choice and Self-Directed Community Resource Delivery
for the Elderly and People with Disabilities in North Dakota

Research Report Two

A Report of Questionnaires Administered to
North Dakota Hospital Discharge Planners

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APPENDICES

The North Dakota Real Choice Systems Change Grant - Rebalancing Initiative, also called the Real Choice Rebalancing (RCR) Grant, is a project funded by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (HHS-CMS). The North Dakota Department of Human Services-Aging Services Division was awarded the three year grant in September 2004. The Aging Services Division established a contract with the North Dakota Center for Persons with Disabilities (NDCPD) to carry out substantial portions of the grant's work scope. The NDCPD is a Center of Excellence at Minot State University. Its role is to apply the experience, knowledge, talent, and research expertise of the university to the challenges facing disability and human services in North Dakota (ND). NDCPD engages in a wide range of research, training, dissemination, and technical assistance activities serving North Dakotans with disabilities, their families, those who work with them, and the agencies and systems serving them. NDCPD is a full member of the Association of University Centers on Disabilities (AUCD), a national network of disability research and training programs at leading universities throughout the country.

The goal of CMS's Real Choice Systems Change Grants is to implement the Olmstead Decision and President Bush's New Freedom Initiative. On June 18, 2001, President Bush directed Federal agencies to work together to "tear down the barriers" to community living by developing a government-wide framework for helping provide elderly and people with disabilities the supports necessary to learn and develop skills, engage in productive work, choose where to live, and fully participate in community life. The Olmstead Decision calls upon states to integrate people with disabilities and provide community-based services.

The overall purpose of the ND RCR Grant is to take an in-depth look at the continuum of care system in the state and how ND can better implement the Olmstead Decision and the New Freedom Initiative. Specifically the RCR Grant goals are:

1. To increase access to, and utilization of, home and community-based services (HCBS) for the elderly and people with disabilities;
2. To provide a finance mechanism for home and community-based programs and services;
3. To increase choice and self-direction for the elderly and people with disabilities;
4. To decrease reliance on institutional forms of care; and
5. To develop a quality management mechanism for service delivery.

This project's consumer and stakeholder-dominated process will gather information and work to build consensus on three key issues:

1. A mechanism to balance state resources for services for the elderly, people with disabilities, and their families in strengthening self-directed services in communities;
2. A system to provide a single point of entry (SPE) to services for the elderly and people with disabilities who are considering long-term HCBS and institutional services in ND; and
3. Practical and sustainable public information services for access to all long-term care services in ND.

This project will also develop a plan and draft potential legislation for balancing resources and establishing a statewide mechanism for single point of entry to the continuum of care services in North Dakota.

Purpose of Research

This Report of Questionnaires Administered to North Dakota Hospital Discharge Planners (HDP), Research Report Two, is part of a larger research project conducted under the RCR Grant. The larger research project also included focus groups, personal interviews, and consumer questionnaires. This report describes the hospital discharge planner survey conducted in the beginning of 2006, the scientific process of this research, and the findings. RCR project staff examined several past ND studies relating to long-term support services. These past studies identified information that has been researched and gave direction for deciding what information was still necessary to gather regarding choice and access to long-term support or continuum of care services.

The HDP questionnaires (see Appendix A) were disseminated to gather information about hospital discharge planners' awareness of choice and access to continuum of care services (i.e. HCBS and nursing home care) for the elderly and people with disabilities as well as to gather ideas about how to optimize choice and improve access to these services. In 2004, 73% of ND nursing home admissions originated from a hospital setting (Issue and Data Book for Long Term Care, 2005, p.21). It was thought that HDPs could potentially be targeted as a group to help the elderly and people with disabilities access a variety of long-term support services, including HCBS and decrease utilization of institutional services. However, the RCR Grant planning and steering committee members (see Appendix B) identified a lack of information from ND hospital discharge planners related to continuum of care services and identified a need to gather HDP input. It was thought necessary to

gather HDP's input regarding their awareness of and recommendations for improving choice and access to all types of long-term support services.

In addition to the discharge planner questionnaire, the RCR Grant also gathered information through questionnaires sent to consumers of continuum of care services. At the time of this writing, the data gathered from the consumer questionnaire is being compiled and a report will be available at a later date. Also as part of the larger research project, focus groups and personal interviews were conducted to gather information about current perceptions and suggestions for improving choice and self-direction, quality, and access to continuum of care services for the elderly and people with disabilities. The focus group and personal interview results are detailed in the RCR Grant Research Report One. The research project's mixed method approach (focus groups, personal interviews, and questionnaires) allows conclusions to be validated through data triangulation.

Research Method

Technique

Throughout the development and implementation of the research project, as well as during the development of the HDP questionnaires, the RCR planning and steering committees provided input and recommendations. Decisions about the participants and questions to be asked were based on their recommendations. This highly interactive process of committee review, input, recommendations, and research refinement was an important aspect of the project, helping to assure the validity of the resulting data. Additionally, this research project was reviewed and approved by the Minot State University Institutional Review Board, following all necessary procedures for the protection of human research subjects.

Using the focus group questions mentioned earlier as a guide the steering committee determined what information was valuable to gather from HDP. Questionnaires were drafted and reviewed by the RCR steering committee. The intent of the instrument was to determine how HDP/hospital social workers become aware of patients in need of discharge planning, how they are educated on the availability of existing services, how much time it takes to develop a discharge plan, if they experience any barriers while discharge planning, and what types of services they regularly recommend to patients. The questionnaire also asked the HDP to describe if an SPE would be useful to them while discharge planning.

To help define what an SPE is, the RCR Steering Committee uses the following SPE description that has been implemented in other states. An SPE is intended to be a service system that provides consumers streamlined access to all long-term and supportive services through one agency or organization or provides an identifiable place where people can get information, objective advice, and access to a wide range of community supports. In this questionnaire, HDPs also had the opportunity to provide recommendations for services an SPE should have available, the location, and who the SPE should serve.

The questionnaires included both quantitative and qualitative items. The qualitative or open-ended questions were included in order to gather additional data to enrich the quantitative information. The questionnaires were developed carefully to exclude gathering any information that may personally identify the participant.

Data Collection and Analysis

RCR project staff compiled a list of all hospitals in ND. Hospitals located in reservation communities were not included in this list due to tribal Institutional Review Board (IRB) requirements for conducting research on reservations which would have necessitated a more lengthy data collection process. The HDP questionnaires were finalized and disseminated in January 2006 when RCR project staff mailed out forty-six questionnaires to forty-six hospitals in ND. As suggested by hospital social workers previously contacted by project staff, the questionnaires were addressed to the Director of Social Work at each hospital and then disseminated to the most appropriate person (e.g. a social worker in charge of geriatric discharge planning). Each questionnaire packet also included an RCR project brochure and a self-addressed stamped return envelope. HDPs were asked to return the questionnaires no later than one week after receipt.

Project staff entered the quantitative responses into the Statistical Package for the Social Sciences (SPSS) analysis software to help organize and compute the data. SPSS is computerized statistical software that allows the use of an array of data collecting, analysis and appearance features. The quantitative responses from several short answer qualitative questions were transcribed and analyzed to look for common themes and patterns. The quantitative data and qualitative common themes and suggestions are included in both graphs and narrative format throughout the report. The graphs and charts included in this report detail the quantitative data gathered. Each graph or chart includes a breakdown of quantitative responses based on the participating HDP's community type, urban or rural/frontier. An overall response section is also incorporated into the charts and

graphs to account for all data collected from urban and rural/frontier community HDPs and also HDPs who did not indicate a community type.

Data Results from the Hospital Discharge Planner Questionnaire

Demographics

The forty-six hospitals included in this survey are located in a variety of communities with various population sizes. Of the forty-six ND hospitals included in the survey mailing, seven of those are located in urban areas of ND, Minot, Bismarck, Fargo, and Grand Forks. The remaining thirty-nine questionnaires sent to HDPs were sent to hospitals located in rural/frontier communities of the state meaning a population of less than 20,000 people.

Of the 46 questionnaires disseminated, 26 were completed with a return rate of 57%. Of those who responded, three (12%) were from an urban community, twenty (76%) were from rural/frontier community hospitals, and three (12%) did not indicate community type (see Figure 1). For the purpose of detailing data by community, frontier communities were combined with rural communities since they both are communities of 20,000 people or fewer. HDPs were also asked to indicate in which DHS region their hospital was located (see Figure 2).

Figure 1

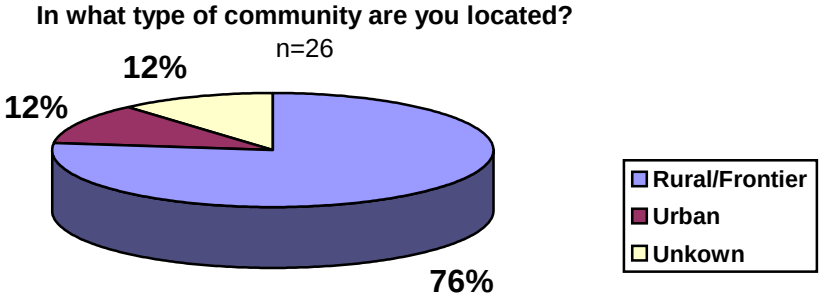
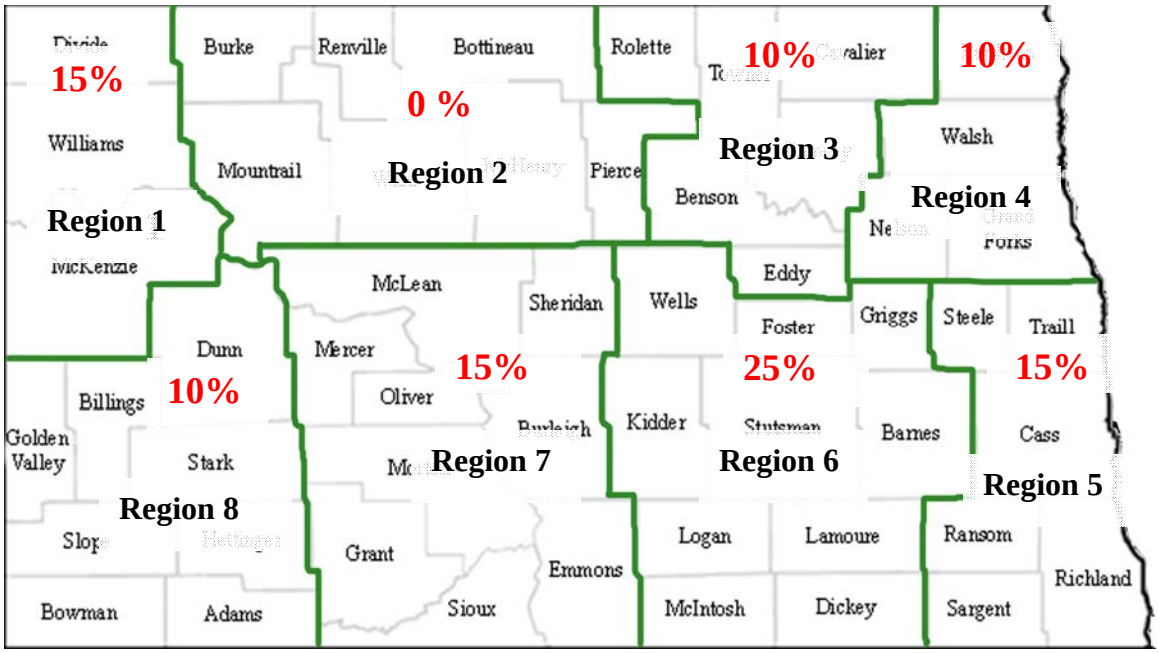


Figure 2

In what Region is your hospital located?

n=20



Some of the rural hospitals surveyed may only have one person who does the discharge planning, while other hospitals have a discharge planner on each floor. Throughout this report the data is detailed to show the responses from urban and rural HDPs and the combined data. The higher rural HDP return rate coincides with the larger number of rural hospitals (thirty-nine) throughout the state as compared to the seven urban hospitals included in the survey mailing.

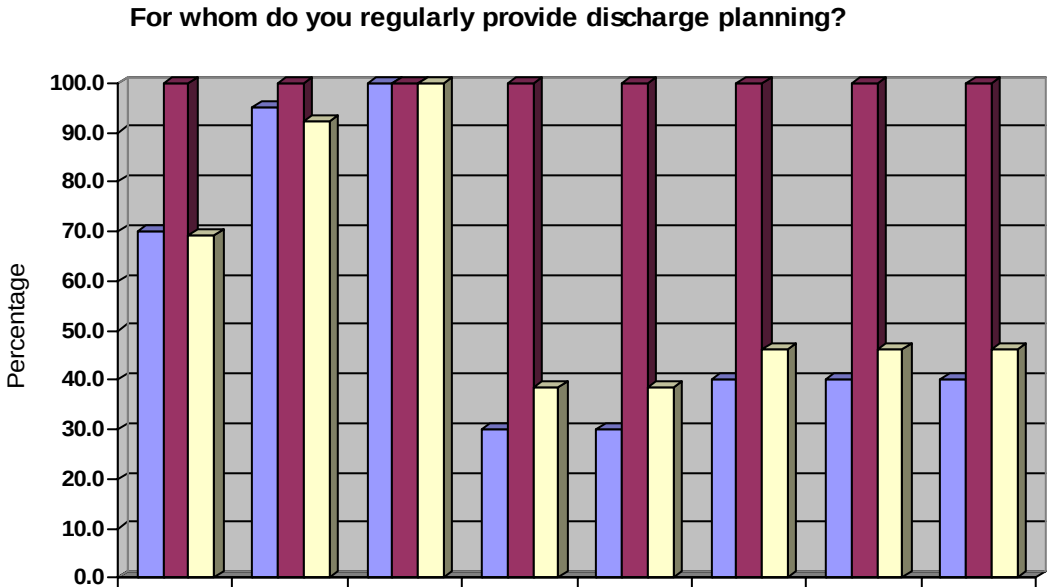
All hospital discharge planners who returned the survey were female. The majority (84%) of HDPs who participated were between the ages of forty to fifty-nine years of age. The overall tenure as an HDP varied from less than one year (8%), one to five years (35%), six to ten years (23%), to eleven or more years (35%).

Discharge Planning

HDPs were asked to indicate all patient age groups to whom they provide discharge planning. All twenty-six respondents indicated they provide discharge

planning for people over the age of 80; and over 46.2% percent of them indicated that they provide discharge planning for people with disabilities age 60 and older. The rural HDPs indicated that they provide discharge planning regularly to the elderly age 60-69, 70-79, and 80 and older. In comparison their urban counterparts indicated they provide discharge planning regularly to all of the age groups identified (see Figure 3). This data indicates that there seems to be a higher concentration of elderly hospital patients in rural hospitals rather than adults with disabilities.

Figure 3



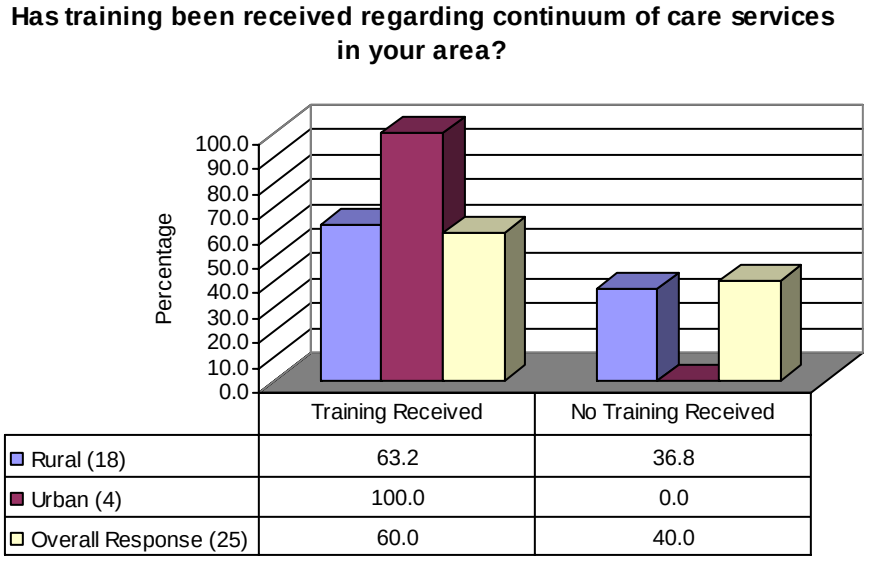
	Elderly Age 60-69	Elderly Age 70-79	Elderly Age 80+	People with Disabilities 21-39	People with Disabilities 40-59	People with Disabilities 60-69	People with Disabilities 70-79	People with Disabilities Age 80+
Rural *	70.0	95.0	100.0	30.0	30.0	40.0	40.0	40.0
Urban *	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Overall Response*	69.2	92.3	100.0	38.5	38.5	46.2	46.2	46.2

* Percentages include only those who responded to each question.

Training. Overall, sixty percent of HDPs surveyed stated they receive training regarding continuum of care services that are available in their communities (see

Figure 4). Training was received by 100% of urban HDPs as compared to 63.2% of rural HDPs (see Figure 4).

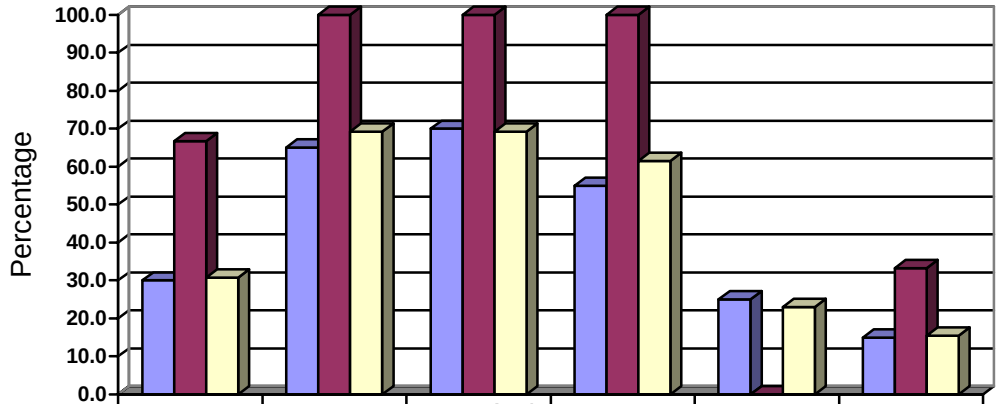
Figure 4



Currently, ND does not have a statewide information resource where all providers or HDPs can access information or training regarding continuum of care services. When asked, HDPs indicated they are finding out about services in a variety of ways. Urban HDPs stay current most often through networking, meetings, by word of mouth, and the internet. Rural HDPs seemed to find it more difficult to remain current about the available continuum of care services, most often learning through word of mouth and networking with community resources (see Figure 5).

Figure 5

How do HDPs stay current regarding available continuum of care services?



	Internet	Word of mouth	Network w/ community resources	Meetings	Difficult	Other
Rural*	30.0	65.0	70.0	55.0	25.0	15.0
Urban*	66.7	100.0	100.0	100.0	0.0	33.3
Overall Response*	30.8	69.2	69.2	61.5	23.1	15.4

*Percentage includes only those who responded to each category.

HDPs also noted other current sources for information and training to include:

- in-service trainings,
- conferences,
- phone contacts,
- community agency group meetings,
- senior citizen coordinators, and
- community resources.

Additional related resources included:

- in-house training,
- Senior Health Insurance Counseling (SHIC) program,
- community resource coordinators,
- information from public health,
- county social services,
- conferences,
- phone contacts,
- state coalition meetings,
- hospice, and
- nursing home social worker communication.

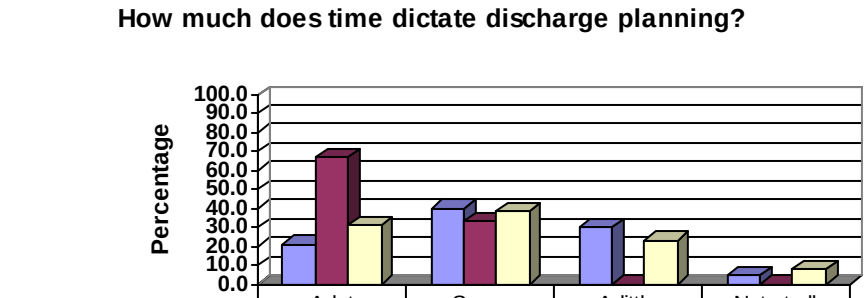
Some HDPs stated that they would like more training on services that are available in their community. Specifically, a need for additional information about:

- Lifeline,
- home health,
- caregiver programs and eligibility criteria for programs like Medicaid,
- Social Security Disability,
- Spousal Program, and
- ND Legal Aid was noted by HDPs (see Appendix D, Question 13).

Awareness. When a patient is admitted to the hospital, HDPs indicated they become aware of patients in need of discharge planning through physicians, nursing referrals, family members, daily team meetings, care conferences, visiting with patients, staff assessment, or reviewing the daily hospital census. In order to assess the needs of the patient during discharge planning, several respondents stated that they would complete mandatory assessments as well as visit with the patient, family members, physicians, and multi-disciplinary team members. HDPs also indicated they review the patient's chart for physician recommendations and past history of conditions and services (see Appendix D, Question 8 & 9).

Barriers. With so many patients in need of discharge planning, HDPs often have minimal time to develop an individualized cohesive plan. The overall data gathered from the discharge planner questionnaire revealed that the majority of HDPs stated that time dictates discharge planning. Only 7.7% of all HDPs surveyed indicated that time *did not* play a factor when discharge planning. Sixty-seven percent of urban HDPs indicated that time dictates their discharge planning *a lot*, compared to 21.1% of rural HDPs (see Figure 6).

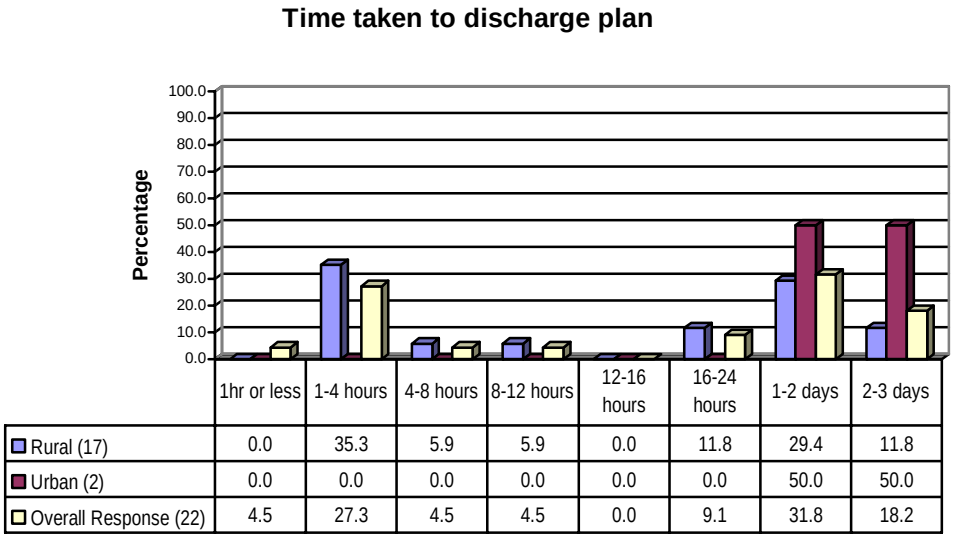
Figure 6



	A lot	Some	A little	Not at all
Rural (19)	21.1	40.0	30.0	5.0
Urban (2)	66.7	33.3	0.0	0.0
Overall Response (26)	30.8	38.5	23.1	7.7

HDPs stated the time to develop a discharge plan for a patient varied from 1-2 days (31.8%) to 1-4 hours (27.3%). Data shows that urban HDPs have more time (1-3 days) to plan a discharge compared to their rural counterparts who have 1-4 hours or 1-2 days (see Figure 7). This range indicates that time is a barrier for some discharge planning. For example, it may take a few hours to set up services for one patient while a different patient's discharge plan may take days to coordinate appropriate and available services. Every situation is unique for each patient; however HDPs indicated that time to develop a plan is often limited and time does dictate planning *a lot* or *some* of the time.

Figure 7



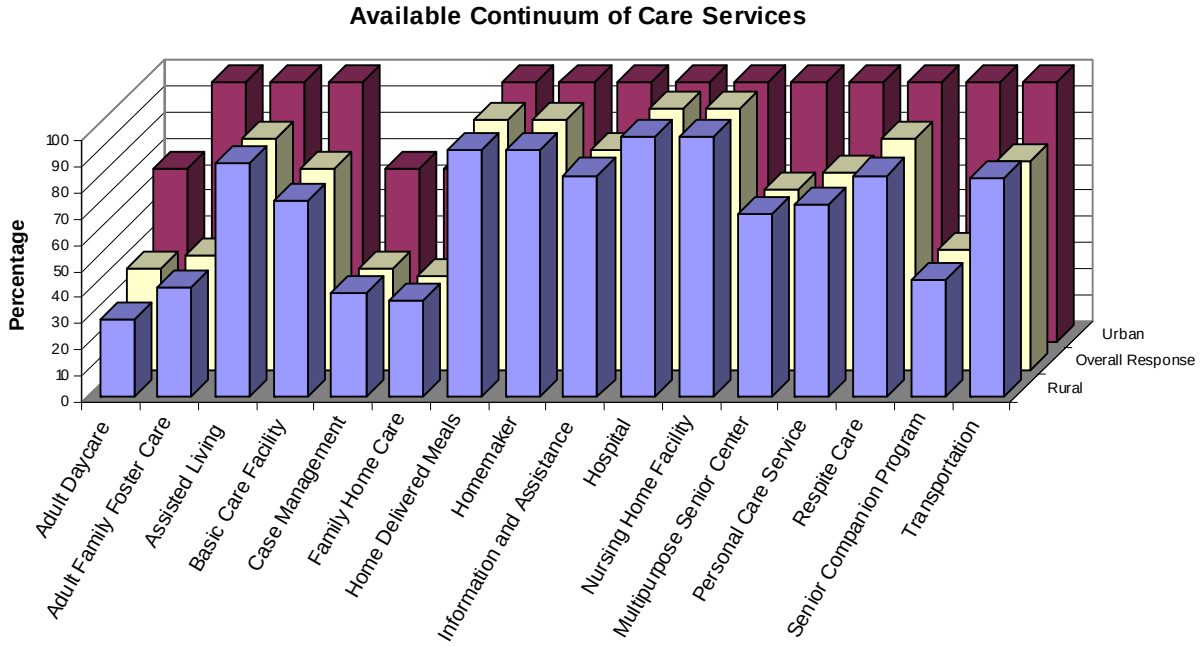
	1hr or less	1-4 hours	4-8 hours	8-12 hours	12-16 hours	16-24 hours	1-2 days	2-3 days
Rural (17)	0.0	35.3	5.9	5.9	0.0	11.8	29.4	11.8
Urban (2)	0.0	0.0	0.0	0.0	0.0	0.0	50.0	50.0
Overall Response (22)	4.5	27.3	4.5	4.5	0.0	9.1	31.8	18.2

Other common barriers noted by HDPs included:

- limitations to what services patients qualify for,
- limited service availability,
- requirements and limitations of insurance coverage,
- service affordability,
- limited availability of some care facilities, and
- matching patient needs with available long-term support services (See Appendix D, Question12).

HDPs indicated they would like to recommend a variety of continuum of care services to consumers, however, several barriers complicate this effort. In rural communities, transportation and availability of continuum of care providers, especially HCBS, are scarce. Rural HDPs who responded indicated several HCBS were available less than 50% of the time. These included Adult Daycare, Adult Family Foster Care, Case Management, Family Home Care, and Senior Companion Program. Urban HDPs indicated services lacking included Adult Daycare, Case Management, and Family Homecare (see Figure 8).

Figure 8



Available	Adult Daycare	Adult Family Foster Care	Assisted Living	Basic Care Facility	Case Management	Family Home Care	Home Delivered Meals	Homemaker
Rural *	30.0	42.1	90.0	75.0	40.0	36.8	95.0	95.0
Urban *	66.7	100.0	100.0	100.0	66.7	66.7	100.0	100.0
Overall Response*	38.5	44.0	88.5	76.9	38.5	36.0	96.2	96.2

Available	Information and Assistance	Hospital	Nursing Home Facility	Multipurpose Senior Center	Personal Care Service	Respite Care	Senior Companion Program	Transportation
Rural *	85.0	100.0	100.0	70.0	73.7	85.0	45.0	84.2
Urban *	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Overall Response*	84.6	100.0	100.0	69.2	76.0	88.5	46.2	80.0

*Percentage includes only those who responded to each category.

One dilemma HDPs experience occurs when trying to access and coordinate services for a patient when these services are not readily available in the community of choice. This dilemma affects the services the HDPs regularly recommend (see Figure 9). Often, rural areas do not offer a great deal of choice of services or personnel to provide services to patients particularly HCBS, so HDPs have to

transfer patients to another community or facility in order to receive the needed services. At times patients cannot afford to pay for services privately. Some services that patients need are not paid for though Medicaid or other assistance programs if provided in the home so patients stay in a swing bed unit or are admitted to a nursing home in order to receive this treatment or service (see Appendix D, Question 12).

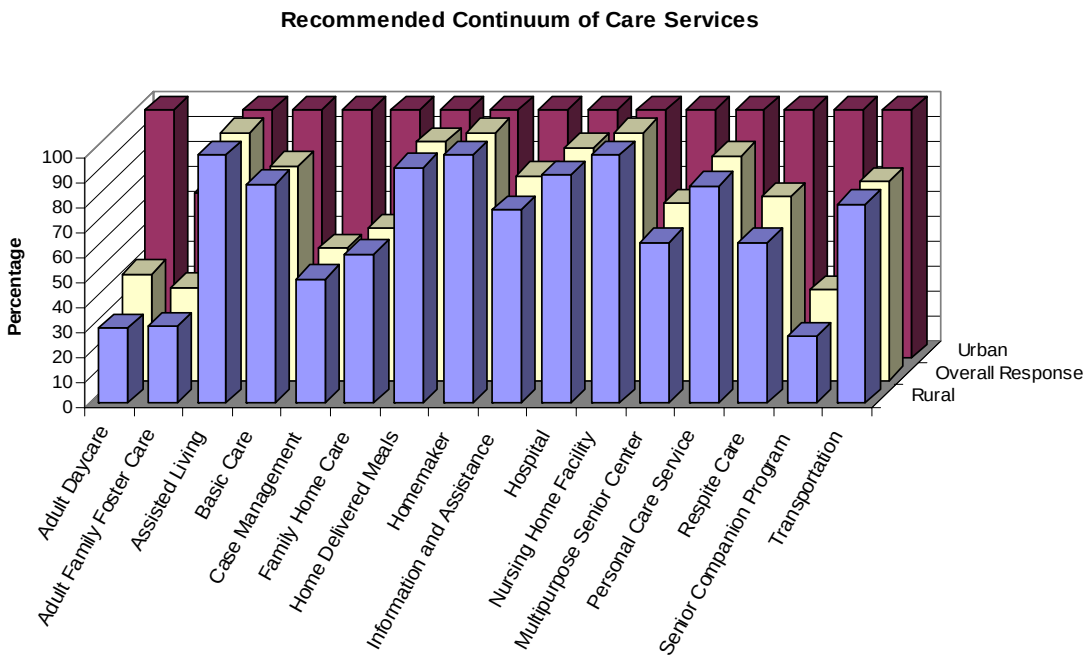
Each community is unique and has different resource needs. Some HDPs said they seek the most appropriate, least restrictive environment so that patients may live as independently as possible (see Appendix D, Question 10 & 11) However, a lack of some continuum of care service options, particularly HCBS, is a barrier patients face when they would like the opportunity to remain as independent as possible (see Figure 9). Some specific continuum of care services that HDPs indicated were lacking or needed expansion included:

- Meals on Wheels – seven days a week,
- homemaker services,
- home caregivers,
- adult daycare,
- transportation seven days a week and at night,
- 24 hour home care,
- respite care,
- personal care,
- affordable housing,
- foster care,
- medication management,
- accessible and affordable housing,
- basic care and nursing home beds, and
- affordable assisted living (See Appendix D, Qualitative Response Summary, Question 15).

One of the purposes of the HDP questionnaire was to gather input from HDPs regarding access to and utilization of HCBS for the elderly and people with disabilities. Figures 8 and 9 show the services HDPs indicated are available in their

communities and are regularly recommended. Of the services from which to choose, nursing homes were the only service recommended and available 100% of the time in both rural and urban communities. Some services were being regularly recommended more often than they were available in the community. For example, personal care service was recommended 90.5% of the time but was available only 76.0% of the time. Other services were noted as being available more often then they were recommended such as the Senior Companion Program and respite care services (See Figure 9).

Figure 9



Recommend	Adult Daycare	Adult Family Foster Care	Assisted Living	Basic Care	Case Management	Family Home Care	Home Delivered Meals	Homemaker
Rural *	30.0	30.8	100.0	88.2	50.0	60.0	94.7	100.0
Urban *	100.0	66.7	100.0	100.0	100.0	100.0	100.0	100.0
Overall Response*	42.9	37.5	100.0	86.4	53.3	61.5	96.0	100.0
Recommend	Information and Assistance	Hospital	Nursing Home Facility	Multipurpose Senior Center	Personal Care Service	Respite Care	Senior Companion Program	Transportation
Rural *	77.8	91.7	100.0	64.7	87.5	64.7	26.7	80.0
Urban *	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Overall Response*	82.6	93.8	100.0	71.4	90.5	73.9	36.8	80.0

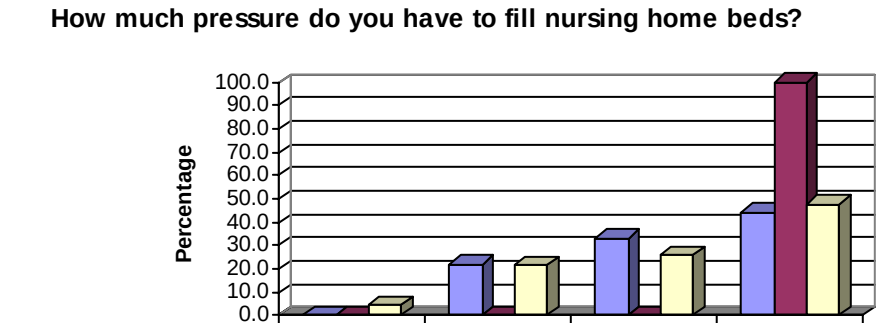
*Percentage includes only those who responded to each category.

As noted previously in 2004, 73% of ND nursing home admissions originated from the hospital (Issue and Data Book for Long Term Care, 2005, p.21). The RCR Steering Committee members wanted to gather information about why this was

occurring. The HDP questionnaire results indicated that 47.8% of all HDPs who responded felt *no pressure* to fill nursing home beds. However, 47.8% had *some* or *a little* pressure and 4.3% indicated they receive *a lot* of pressure to fill nursing home beds or refer patients to nursing home services. When looking at the pressure to fill nursing home beds by community types, 55.5% of rural HDPs indicated that they feel *some* or *a little* pressure to fill nursing home beds while 100% of urban HDPs indicated no pressure. Also noteworthy is that the three HDPs who did not indicate which community type they were from were also the only HDPs who stated they receive *a lot* of pressure to fill nursing home beds (see Figure 10).

In North Dakota's rural communities the nursing home is often the only well known and easily accessed source of continuum of care services to both consumers and HDPs. Often there are limited resources to provide HCBS in rural communities and thus the nursing home is most often utilized. The dwindling rural population in ND and possible competition among rural providers to serve consumers may occur because without people to serve there is no income. These three scenarios may be reasons for differences in pressure to fill nursing home beds in rural and urban communities.

Figure 10

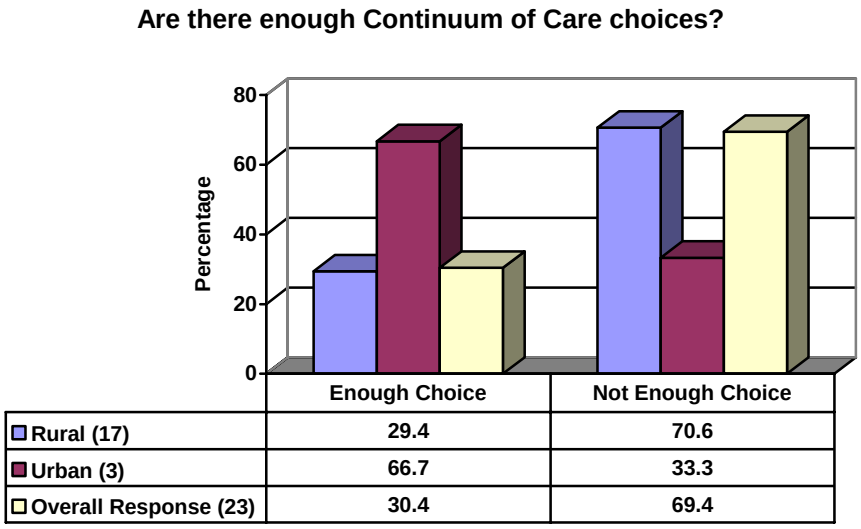


	A lot	Some Pressure	A little Pressure	No Pressure
Rural (18)	0.0	22.2	33.3	44.4
Urban (2)	0.0	0.0	0.0	100.0
Overall Response (23)	4.3	21.7	26.1	47.8

Single Point of Entry (SPE)

Access to choices and information about continuum of care services for the elderly and people with disabilities is a concern for discharge planners. Nearly 70% of all HDPs responded that there are not enough choices to offer patients regarding continuum of care services. Thirty-three percent of urban HDPs reported that there are not enough choices of continuum of care services while 70.6 % of rural HDPs reported a lack of continuum of care choices in their communities (see Figure 11). This is consistent with previous data about availability of services and that in particular, rural HDPs indicated a lack of continuum of care services.

Figure 11

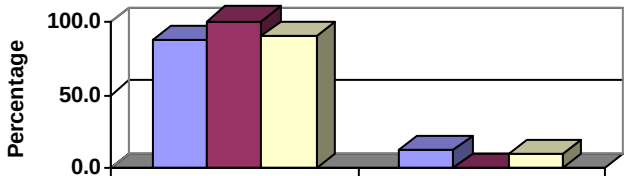


	Enough Choice	Not Enough Choice
Rural (17)	29.4	70.6
Urban (3)	66.7	33.3
Overall Response (23)	30.4	69.4

Overall 90.5% of HDPs said that an SPE would be helpful while providing discharge planning (Urban = 100%; Rural = 87.5%) (see Figure 12). The majority of participants indicated that an SPE should include information about continuum of care services, benefit information, eligibility, evaluation or assessments, financial information, and case management (see Figure 13). HDPs indicated that an SPE should offer family support and guidance and be available for everyone. Also, HDPs indicated that an SPE should provide specific contact information for service providers as well as information about all long term support resources available, including housing assistance (see Appendix D, Question 13 & 16).

Figure 12

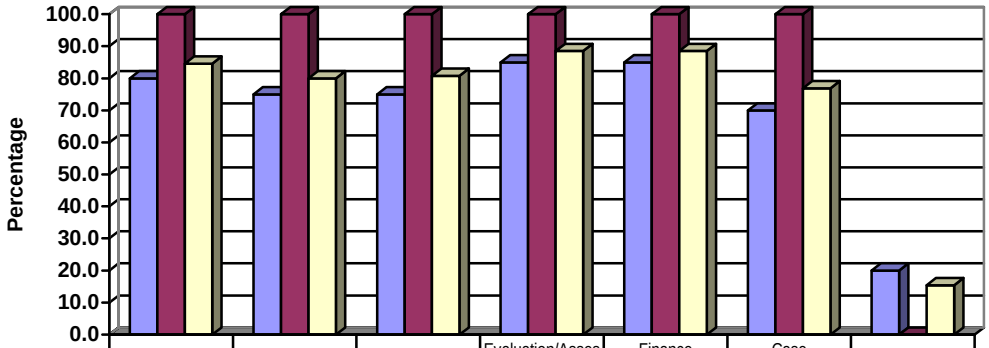
Would Single Point of Entry be helpful for discharge planning?



	Would be helpful	not helpful
Rural (15)	87.5	12.5
Urban (4)	100.0	0.0
Overall Response (21)	90.5	9.5

Figure 13

What should the Single Point of Entry have available?



	Service Info	Benefit Info	Eligibility	Evaluation/Assessment	Finance Information	Case Management	Other
Rural	80.0	75.0	75.0	85.0	85.0	70.0	20.0
Urban	100.0	100.0	100.0	100.0	100.0	100.0	0.0
Overall Response	84.6	80.0	80.8	88.5	88.5	76.9	15.4

*Percentage includes only those who responded to each category.

Additional suggestions for the development of an SPE were also gleaned from this questionnaire. For example, an SPE should be placed in a neutral entity that could represent all facets available. The SPE should be available at least five days per week and have an "off hours" contact number. Having a telephone number with a real person (not automated) was also noted as important. The SPE contact person should be very friendly and easy to access and understand. Persons

working at the SPE should be able to explain services and costs upfront and provide information and referral upon request. The intake worker of the SPE should be able to identify eligibility for services and may even provide home visits, especially in rural areas. Some HDPs indicated that the SPE should also be available for all ages.

Suggestions for SPE locations included hospitals, senior centers, clinics, county social services, community-wide social service offices, public libraries, court houses, and grocery stores. More SPE location detail included availability in each county, each rural town, in a state agency, and through Older Americans Act Providers. HDPs suggested the SPE should be a comfortable place where people can access it daily (see Appendix D, Question 16, 17, 18, & 19).

It was also noted that the SPE would be helpful for HDPs for the following reasons:

- SPE would not have to send people to a variety of different places,
- SPE would be used by professionals, families, and consumers to help them access information easily,
- SPE would eliminate a lot of the "red tape",
- SPE could prevent hospital re-admissions, and
- SPE staff would be aware of resources available in all rural towns.

HDPs also noted a SPE would be convenient for the patients and families, time saving, less confusing, and involve less telephone work(more face to face). One concern recorded on the survey was that an SPE may interfere with the current process. This particular HDP felt that there is an effective system currently in place. If SPE is going to happen, the transition to a new system should be seamless. Many HDPs believe it would be a great tool and resource for the providers and consumers of ND (see Appendix D, Question 16, 17, 18, & 19).

Conclusions/Recommendations

Based on the results of this research data the following conclusions and recommendations have been identified:

1. HDPs, physicians, hospitals and clinics should be targeted with training and on-going education and updates regarding locally available options for continuum of care services for the elderly and people with disabilities. Particular training emphasis should be made in the rural communities.

2. Resources should be provided to HDPs to help them save time, stream line the discharge planning process, and effectively provide an array of appropriate options for patients and their families.

3. A single point of entry system should be developed to be easily accessed by HDPs, physicians, families and patients and to be used as a tool to provide a full array of continuum of care options for patients. The SPE should have available a streamlined assessment process, eligibility assistance, case management, benefit and financial information, and service availability information. This system should provide up-to-date information about long term care support services and be a user friendly place that can be accessed daily.

4. The SPE should be strategically targeted and marketed to HDPs, physicians and hospital and clinic staff. The SPE should be marketed as a resource tool to assist HDPs, physicians, families, and consumers to help individuals stay as independent as possible.

5. Availability, resources, support, and marketing for a variety of continuum of care services should be expanded emphasizing HCBS. Resources, support, and marketing should focus on HCBS with particular attention to those indicated by

HDPs as lacking such as: Adult Day Care, Adult Family Foster Care, Family Home Care, Senior Companion Program, Personal Care Services, and others. Expansion of HCBS services and marketing of them will work to increase usage and decrease reliance on institutional forms of care.

6. Pressure felt by HDPs to fill nursing home beds should be eliminated, especially in rural/frontier communities. A continuum of care system should be in place to ensure that HDPs are able to focus discharge planning on the consumer and his/her needs. Through the process of giving patients and families options, the consumer will have the opportunity for choice and self-direction.

Appendix A

Hospital Discharge Planner Questionnaire

North Dakota Rebalancing Initiative
Real Choice Systems Change Grant

Hospital Social Worker/Discharge Planner Questionnaire

Thank you for participating in the ND *Real Choice Rebalancing - Choice and Self-Directed Community Resource Delivery for the Elderly and People with Disabilities* project. This is a grant that was awarded to the ND Department of Human Services – Aging Services and contracted to the North Dakota Center for Persons with Disabilities. We are gathering information from hospital social workers/discharge planners about **continuum of care services** for the elderly and adults with disabilities.

Continuum of care services include things such as: *assistance with bathing, dressing, transferring, taking medications, transportation, shopping, housework, home delivered meals, in home skilled nurse care, assisted living, nursing homes, etc. These services are designed to assist the elderly and people with disabilities to manage daily living needs and maximize independence. These services can be delivered in a variety of ways and in a variety of environments.*

The information gathered from this questionnaire will be used to develop a statewide plan to make it easier for patients to stay independent as they age through improved access to continuum of care services. Your input is very important to this process.

Your answers will be kept strictly confidential and your privacy will be protected at all times. If you have any questions about this questionnaire or the Real Choice Rebalancing project, please contact Amy Armstrong, Project Director, at (800)233-1737, or if you have any questions about the rights of human research subjects please contact Dr. Margi Coxwell, chair of the MSU Institutional Review Board at (701) 858-3125.

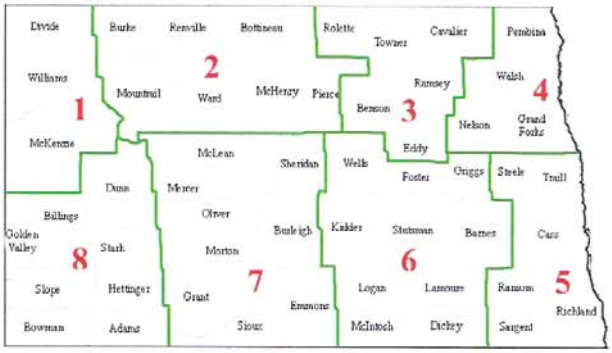
Please complete and return the questionnaire in the postage paid envelope to:
Amy Armstrong, Minot State University/NDCPD, 500 University Avenue West, Minot, ND 58707.

Please return your completed questionnaire no later than one week after receipt.

Thank you for your participation.

Please contact NDCPD for alternative formats or additional surveys: (800) 233-1737

1. Circle the region that your hospital is located in:



2. What type of community is this?
   - ☐ Urban community (20,000 people and over)
   - ☐ Rural community (Under 20,000 people)
   - ☐ Frontier/very rural

3. For whom do you regularly do discharge planning? (check all that apply)
   - ☐ Elderly *Age 60-69*
   - ☐ Elderly *Age 70-79*
   - ☐ Elderly *Age 80 or over*
   - ☐ People with Disabilities *Age 21-39*
   - ☐ People with Disabilities *Age 40-59*
   - ☐ People with Disabilities *Age 60-69*
   - ☐ People with Disabilities *Age 70-79*
   - ☐ People with Disabilities *Age 80 or over*

4. How do you stay current regarding available continuum of care services?
   - ☐ Internet
   - ☐ Word of Mouth
   - ☐ Network with community resources
   - ☐ Meetings
   - ☐ It is difficult to stay current
   - ☐ Other _____

5. How does time dictate your discharge planning?
   - ☐ A lot
   - ☐ A little
   - ☐ Some
   - ☐ Not at all

6. How much time do you usually have to make discharge plans for patients?
   - ☐ 1 hour or less
   - ☐ 1 – 4 hours
   - ☐ 4 – 8 hours
   - ☐ 8 – 12 hours
   - ☐ 12 – 16 hours
   - ☐ 16 – 24 hours
   - ☐ 1 – 2 days
   - ☐ 2 – 3 days
   - ☐ 3 or more days

7. What amount of pressure do you receive to fill Nursing Home beds?
   - ☐ A lot of pressure
   - ☐ A little pressure
   - ☐ Some pressure
   - ☐ No pressure

8. How do you become aware of hospital patients in need of discharge planning?

   _____

   _____

9. How do you assess the needs of the patient during discharge planning?

   _____

   _____

10. What choices of *continuum of care* services do you give patients and/or families during discharge planning?

    _____

    _____

11. What *continuum of care* services would you like to recommend to patients and/or families?

    _____

    _____

12. What barriers do you have in recommending *continuum of care* service to patients?

    _____

    _____

13. Have you received training regarding available *continuum of care* services in your area?
    - ☐ Yes
    - ☐ No

    If YES, what kind of training do you get? _____

    _____

    If NO, what kind of training would you like to get? _____

    _____

14. What types of *continuum of care* services are available in your community and which services do you regularly recommend to people? (Please mark carefully)

	Available			*Regularly Recommend*	
	YES	NO	NOT SURE	YES	NO
Adult Day Care - program of nonresidential activities for individuals age 18 years of age and over that encompasses activities needed to ensure the optimal functioning of the individual – program provided for 3 or more hours per day, on a regular basis, one or more days per week	❑	❑	❑	❑	❑
Adult Family Foster Care - safe, family living environment providing 24 hour care or supervision – licensed by the state.	❑	❑	❑	❑	❑
Assisted Living - an apartment where help with personal needs such as bathing, grooming, medicine, and such can be provided	❑	❑	❑	❑	❑
Basic Care Facility - room, board and non-nursing services provided on a 24 hour basis	❑	❑	❑	❑	❑
Case Management - assessment, care planning, provider selection, monitor services, makes referrals	❑	❑	❑	❑	❑
Family Home Care - provision of room, board, supervisory care, and daily personal care, to an eligible elderly or disabled individual residing with the client in the home of the provider or the home of the client	❑	❑	❑	❑	❑
Home Delivered Meals - meals that meet daily nutritional requirements and are delivered to the home of an eligible individual	❑	❑	❑	❑	❑
Homemaker - provides assistance to persons that have an occasional need for minimal routine assistance with general light housework, laundry, and meal preparation	❑	❑	❑	❑	❑
Information & Assistance - service for older adults, families of older adults and professionals that provides current information about opportunities and services available to individuals within their communities	❑	❑	❑	❑	❑
Hospital -	❑	❑	❑	❑	❑
Nursing Home Facilities - facilities that provide long-term care, including 24-hour nursing care in a congregate institutional environment	❑	❑	❑	❑	❑
Multipurpose Senior Center - a community facility for the organization and provision of a broad spectrum of services, which includes the provision of health, social, nutritional, educational, and recreational activities	❑	❑	❑	❑	❑
Personal Care Service - assistance with daily personal care, i.e. bathing, dressing, transferring, toileting, supervising	❑	❑	❑	❑	❑
Respite Care - services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care	❑	❑	❑	❑	❑
Senior Companion Program (SCP) – senior companions (60 years or older) provide assistance and friendship to seniors who have difficulty with their daily living tasks by helping them retain their independence rather than having to move	❑	❑	❑	❑	❑
Transportation - transporting and / or escorting client for essential needs, i.e. grocery, utility company, Social Security office	❑	❑	❑	❑	❑
Other:_____	❑	❑	❑	❑	❑

Appendix B

Real Choice Rebalancing
Steering Committee Members

Real Choice Rebalancing
Steering Committee Members

First	Last	Agency
Linda	**Wurtz** / Janis Cheney */ Marlowe Kro*	**AARP North Dakota**
Kathy	Hogan / DeLana Duffy-Aziz *	Cass County Social Services
Jane	Strommen	Community of Care Cass County
Rodger	Wetzel	Community Health and Eldercare, St. Alexius Medical Center
Mark	Kolling	Developmental Disabilities Division (DD)
Carol	Olson / Tove Mandigo *	Dept. of Human Services, Director
Linda	**Wright** / Robin Schumacher *	**DHS, Aging Services Division**
Maggie	Anderson	DHS, Medical Services Division
Karin	Mongeon*	DHS, Medical Services Division
JoAnne	Hoesel	DHS, Mental Health and Substance Abuse Division
Gordon	Hauge / Marilyn Bender *	Easter Seals Goodwill of ND
Chuck	Stebbins / Mark Bourdon*	Freedom Resource CIL / Consumer
Amy	Clark	Governor's Committee on Aging
Duane	**Houdek**	**Legal Counsel to the Governor**
Cheryl	Kulas	Indian Affairs Commission
Theresa	Snyder	DHS / Tribal Liaison & Program Civil Rights Officer
Marcia	Sjulstad / Jo Burdick *	ND Association for Home Care
Darleen	Bartz	ND Dept. of Health, Division of Health Facility
James	**Moench**	**NDDAC**
Shelly	Peterson	ND Long Term Care Assoc.
Kurt	Stoner*	ND Long Term Care Assoc./ Bethel Lutheran Home
Tom	Alexander	Comprehensive Employment Systems Grant/NDCPD
Bonnie	Selzler	Olmstead
Bruce	Murry / Teresa Larsen *	Protection and Advocacy
Amy	**Armstrong** / Kylene Kraft	**Real Choice Rebalancing Grant/NDCPD**
MariDon	Sorum / Sandy Arends*	Regional Aging Services Program Admin. North Ctrl. Human Ser. Ctr.-
Sandy	Arends / MariDon Sorum*	Regional Aging Services Program Admin.- SE Human Service Center
Gary	Kreidt	Representative
Richard	Dever	Senator
Bob	Puyear	Consumer
Ellen	Owen	Burleigh County Senior Adults Program

* Indicates alternate representative

Indicates RCR Planning Committee Member

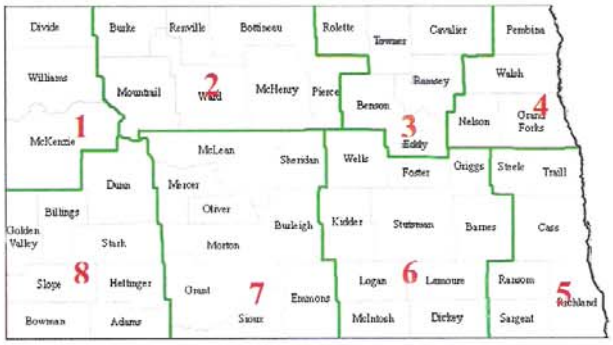
Appendix C

Hospital Discharge Planner Questionnaire

Quantitative Data Results
Overall Responses

Discharge Planner/Social Worker Questionnaire Percentage Results

1. Circle the region that your hospital is located in:



n=20
region 1 = 15%
region 2 = 0%
region 3 = 10%
region 4 = 10%
region 5 = 15%
region 6 = 25%
region 7 = 15%
region 8 = 10%

2. What type of community is this? n=23
   - ☐ Urban community (20,000 people and over) 17.4%
   - ☐ Rural community (Under 20,000 people) 65.2%
   - ☐ Frontier/very rural 17.4%

3. For whom do you regularly do discharge planning? (check all that apply)
   - ☐ Elderly *Age 60-69* 69.2%
   - ☐ Elderly *Age 70-79* 92.3%
   - ☐ Elderly *Age 80 or over* 100%
   - ☐ People with Disabilities *Age 21-39* 38.5%
   - ☐ People with Disabilities *Age 40-59* 38.5%
   - ☐ People with Disabilities *Age 60-69* 46.2%
   - ☐ People with Disabilities *Age 70-79* 46.2%
   - ☐ People with Disabilities *Age 80 or over* 46.2%

4. How do you stay current regarding available continuum of care services? n=25
   - ☐ Internet 30.8%
   - ☐ Word of Mouth 69.2%
   - ☐ Network with community resources 69.2%
   - ☐ Meetings 61.5%
   - ☐ It is difficult to stay current 23.1%
   - ☐ Other _____ 15.4%

5. How does time dictate your discharge planning? n=26
   - ☐ A lot 30.8%
   - ☐ A little 23.1%
   - ☐ Some 38.5%
   - ☐ Not at all 7.7%

6. How much time do you usually have to make discharge plans for patients? n=22
   - ☐ 1 hour or less 4.5%
   - ☐ 1 – 4 hours 27.3%
   - ☐ 4 – 8 hours 4.5%
   - ☐ 8 – 12 hours 4.5%
   - ☐ 12 – 16 hours 0%
   - ☐ 16 – 24 hours 9.1%
   - ☐ 1 – 2 days 31.8%
   - ☐ 2 – 3 days 18.2%
   - ☐ 3 or more days 0%

7. What amount of pressure do you receive to fill Nursing Home beds? n=23
   - ☐ A lot of pressure 4.3%
   - ☐ A little pressure 26.1%
   - ☐ Some pressure 21.7%
   - ☐ No pressure 47.8%

13. Have you received training regarding available *continuum of care* services in your area? n=25
   - ☐ Yes 60%
   - ☐ No 40%

14. What types of *continuum of care* services are available in your community and which services do you regularly recommend to people? (Please mark carefully)	*Available*			*Regularly Recommend*	
	YES	NO	NOT SURE	YES	NO
Adult Day Care - program of nonresidential activities for individuals age 18 years of age and over that encompasses activities needed to ensure the optimal functioning of the individual – program provided for 3 or more hours per day, on a regular basis, one or more days per week	38.5% ❑	61.5% ❑ n=26	0% ❑	42.9% ❑ n=14	57.1% ❑
Adult Family Foster Care - safe, family living environment providing 24 hour care or supervision – licensed by the state.	44.0% ❑	44.0% ❑ n=25	12.0% ❑	37.5% ❑ n=16	62.5% ❑
Assisted Living - an apartment where help with personal needs such as bathing, grooming, medicine, and such can be provided	88.5% ❑	11.5% ❑ n=26	0% ❑	100% ❑ n=23	0% ❑
Basic Care Facility - room, board and non-nursing services provided on a 24 hour basis	76.9% ❑	23.1% ❑ n=26	0% ❑	86.4% ❑ n=22	13.6% ❑
Case Management - assessment, care planning, provider selection, monitor services, makes referrals	38.5% ❑	42.3% ❑ n=26	19.2% ❑	53.3% ❑ n=15	46.7% ❑
Family Home Care - provision of room, board, supervisory care, and daily personal care, to an eligible elderly or disabled individual residing with the client in the home of the provider or the home of the client	36.0% ❑	52.0% ❑ n=25	12.0% ❑	61.5% ❑ n-13	38.5% ❑
Home Delivered Meals - meals that meet daily nutritional requirements and are delivered to the home of an eligible individual	96.2% ❑	3.8% ❑ n=26	0% ❑	96.0% ❑ n=25	4.0% ❑
Homemaker - provides assistance to persons that have an occasional need for minimal routine assistance with general light housework, laundry, and meal preparation	96.2% ❑	3.8% ❑ n=26	0% ❑	100% ❑ n=25	0% ❑
Information & Assistance - service for older adults, families of older adults and professionals that provides current information about opportunities and services available to individuals within their communities	84.6% ❑	11.5% ❑ n=26	3.8% ❑	82.6% ❑ n=23	17.4% ❑
Hospital -	100% ❑	0% ❑ n=19	0% ❑	93.8% ❑ n=16	6.3% ❑
Nursing Home Facilities - facilities that provide long-term care, including 24-hour nursing care in a congregate institutional environment	100% ❑	0% ❑ n=26	0% ❑	100% ❑ n=25	0% ❑
Multipurpose Senior Center - a community facility for the organization and provision of a broad spectrum of services, which includes the provision of health, social, nutritional, educational, and recreational activities	69.2% ❑	26.9% ❑ n=26	3.8% ❑	71.4% ❑ n=21	28.6% ❑
Personal Care Service - assistance with daily personal care, i.e. bathing, dressing, transferring, toileting, supervising	76.0% ❑	16.0% ❑ n=25	8.0% ❑	90.5% ❑ n=21	9.5% ❑
Respite Care - services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care	88.5% ❑	11.5% ❑ n=26	0% ❑	73.9% ❑ n=23	26.1% ❑
Senior Companion Program (SCP) – senior companions (60 years or older) provide assistance and friendship to seniors who have difficulty with their daily living tasks by helping them retain their independence rather than having to move	46.2% ❑	26.9% ❑ n=26	26.9% ❑	36.8% ❑ n=19	63.2% ❑
Transportation - transporting and / or escorting client for essential needs, i.e. grocery, utility company, Social Security office	80.0% ❑	16.0% ❑ n=25	4.0% ❑	80% ❑ n=20	20% ❑
Other: _____	❑	❑	❑	❑	❑

15. Do you feel like there are enough choices of *continuum of care* services available for the elderly and people with disabilities in your community? n=23

☐ Yes 30.4% ☐ No 69.6%

18. What should the single point of entry to *continuum of care* services have available?(Check all that apply)

☐ Services84.6% ☐ Benefit Information80.8% ☐ Eligibility80.8% ☐ Evaluation/Assessment88.5%
☐ Financial Information88.5% ☐ Case management76.9% ☐ Other:_____15.4%
(Medicare/Medicaid)

19. Would a single point of entry system be helpful to you in discharge planning? n=21

☐ Yes 90.5% ☐ No 9.5%

20. How long have you been in your current position? (optional) n=26

☐ Less than one year 7.7% ☐ Six to ten years 23.1%
☐ One to five years 34.6% ☐ Eleven years or more 34.6%

21. What is your age? (optional) n=26

☐ 21 – 39 11.5% ☐ 60 – 69 3.8%
☐ 40 – 59 84.6% ☐ 70 or older 0%

22. What is your gender? (optional) n=26

☐ Male 0%
☐ Female 100%

Appendix D

Hospital Discharge Planner

Qualitative Data Responses

Hospital Discharge Planner Questionnaire
Qualitative Data/Short Answer Responses

Question 8. How do you become aware of hospital patients in need of discharge planning?

- Notified by physician or charge nurse
- weekly discharge/Medicare meetings
- Nursing referrals
- I am also the 8B coordinator so I am aware of admissions and also work closely with nursing staff
- notification from charge nurse
- From Dr., nurses, referrals, family, care conferences, morning meeting
- Nursing staff let me know. I try to get info from Dr. notes and orders.
- Internal communication policies and procedures. Physician orders (I am usually involved from day 1)
- Discharge planning is held Monday to Friday 8:30 AM
- Interview with patients, their families, hospital staff
- Daily census
- physician's orders in the chart; nursing staff referral; daily census summary sheet
- Multi disciplinary daily team meetings, High risk admission criteria established
- We are a small facility; therefore I am able to look at all acute patients and SWB residents on a daily basis
- I am the facility social worker/discharge planner
- We visit with every patient in our facility regarding discharge arrangements
- Nursing make contact per phone or in person
- Automatic referrals to specialty floors (Rehab, OB, sub acute psychiatry) Case manager; physicians/ nursing referrals
- Staff-family-physicians
- I am working on a nursing unit in acute care
- Doctors, nursing staff, my assessment of patient/family
- Referral from MD, nursing staff
- Our staff assess each hospital admit for needs and anyone can refer to discharge planning
- MD orders, screens, patient/family, staff requests
- Staff informs me, Dr. Referral, if person is elderly or has difficulty moving around and lives alone then I will visit
- Daily review of census an/or physician order

Question 9. How do you assess the needs of the patient during discharge planning?

- Visit with the patient, family, nurse, and provider. Have discharge planning committee meeting- look at all aspects of care needed
- look at what they and family want/need- Dr. recommendation
- meet with patient, visit with family, review chart, assess
- interview patient/family/concerned individuals
- Verbal interview

- Chart review, nursing/physician review, PT/OT evaluations, team assessment, care conferences resident/family
- Frequent visits with patients, weekly care plan conference with patient and medical staff, necessary assessment per patient needs done
- activities of daily living abilities
- Discharge planning team consists of team leader, patient care coordinator and social worker
- interview of patients, families, other caregivers
- interview them and family
- direct contact with patient/resident; family input; physician recommendation
- Multi disciplinary team members-including: Dr. RN, Care coordinator, Patient or family
- Questions regarding present home set-up- If more concerns, am usually able to get a home safety evaluation done by OT services
- visits, chart, family and nursing staff
- all areas of health care are present during discharge planning and we discuss options, patients desires, services available for each patient
- group process with nurses, social services, PT, OT, business office
- psychosocial forms completed while interviewing patient gathering date from charts/physicians, PT and family
- visiting- contact services initialized in past according to how thing were going
- through assessment, interdisciplinary team meeting and interviewing the patient
- I complete a Psycho-social assessment with patient, meet with family, discuss with medical staff IE nursing and patients physician
- review chart, speak with staff, MD, interview patient, family (caregiver)
- multidisciplinary and inclusion of patient and family
- on admissions per present criteria, per discharge planning meetings, MD order or screens
- visit with them and find out what they do for themselves, visit with family also
- review of record, personal visit

Question 10. What choices of continuum of care services do you give patients and/or families during discharge planning?

- Lifeline, home health services, meals on wheels, alternative placements such as nursing home, swing bed, basic care, assisted living
- all that are available for hospital(2), home care(3)
- SNF, basic care, assisted living apartments, extended care homemaking and/or personal care, medication planner set up, home health, meals on wheels
- home health, MOW, home help, public health
- home health care county social services
- home services, foster care, basic care, LTC
- Whatever I know is available in their area or close by such as medical equipment, senior respite care, homemakers, follow-up visits, etc.
- home/ swing bed/ LTC/ network with other communities for availability of services
- Home Health, Public Health, nursing home referral
- we look at all levels of care-patient and families are given many choices
- all available

- home care; meals on wheels; county homemaker services; help from local individuals for a fee; available day care; respite care; NH facilities
- Options for all available/appropriate resources- Meals printed handout
- Homemaker services, basic care, LTC, meals on wheels etc.
- Which ever is appropriate and available in our area
- Home care, meals on wheels(MOW), county social services ;homemaker, senior services outreach senior companion, caregivers, NH, assisted living apartments
- All available that would pertain to patient
- Home health agencies, NH, MOW, transit assisted living/ Basic care facilities, NH Adult foster care, adult day care, Medicaid in home care services
- Varies
- We tell them what recommendations for follow up are and what services are available in their area
- Home care, Nursing home info, basic care info, activities of daily living assistance, county services, living well info. What ever is applicable to patient/family
- Homemaker service, meals on wheels, home health care, hospice
- from home/community based services to long term acute
- all that are relevant to their situation
- Home health/public health, any community service available
- whatever's available in their area

Question 11. What continuum of care services would you like to recommend to patients and/or families?

- hospice, homecare, meals on wheels
- all of above
- in home caregivers your pts who do not qualify for home health
- Depends on needs- we start at the lowest level of care that is appropriate, we have a high rehab rate alone and discharge from our LTC. Our goal is to have people as independent as possible
- I would like to see actual in-home hospice here, more home health, homemaker services
- Home services for monitoring safety, check on vitals and making sure they are okay
- the least restrictive
- 24 hour home care- which is not readily available
- more in home assistance; better transportation services in rural areas
- We recommend all needed. Home health care- meals on wheels-
- meals on wheels X 7 days
- varies from individual to individual
- any that apply to the situation
- assisted living in our community- we currently do not have either basic care or assisted living as an option
- respite services example of location: Short Term in nursing homes, Acute Care/Basic Care or foster care however, respite needs to be affordable
- varies- home health –homemakers-nursing home/swing bed- meals on wheel- DME- lifeline/etc.
- what ever they need

- adult day care that was affordable and provided transportation. We have a huge gap in this area. We have many seniors of memory problems that this service could postpone NH admission for
- Homemaker service, meals on wheels, home health care, hospice
- more availability/ areas to home/community based
- private in home caregivers, private duty nursing- for 24 hour care

Question 12. What barriers do you have in recommending continuum of care service to patients?

- Time
- patients don't want to pay for care or services
- availability of services, in care levels of patients, availability of staff to provide services
- we don't have much available
- IV therapy in the home, Home health. Our residents who need 6 months of IV antibodies would need to stay in our swing bed
- we are such a small community, limited resources and people to justify and fund certain programs
- not having all services available and having to transfer our community members to another community to receive needed care
- qualify for home health- i.e.: not always home bound but needs someone coming in home to check on them. Finances
- availability of services in rural areas, cost factors
- as stated above (stated above: 24 hour home care- which is not readily available)
- lack of transportation' home care limits'
- rural community resources limited. Often no NH beds available
- very limited with assisted living services in community
- rural area and somewhat limited resources/ staff in which to save the needs for our increasing aging population
- space available in apartments and NH, distance out of the service area
- cost to patients
- cost of services available
- cost
- none in recommendations but often cost of service is an issue for patients and family
- financial either people don't have the money to spend for additional services or they won't spend the money. Also when dementia or stoicism is involved its almost impossible to convince the person they would benefit from assistance
- availability requirements for county social services programs, lack of special needs meal providers in our area, limitations on days per week service can be provided (HHC,HHA, Hospice) in outlying areas (where providers are located), shortages of assisted living facilities
- lack of funds either private or public
- lack of 24 hour in home caregivers- especially in smaller communities
- depends on need of the person and availability of resources

Question 13. a) If YES, what kind of training do you get?

- In-house training by other employees

- Social work degree, SHIC, community resource coordinator education
- Some training in what services we have available. Have had to find a lot of my own resources
- aging services
- healthy community team meets monthly, includes hospice and nursing home social workers, public health, senior citizen coordinators and county social service for 2 counties that we serve
- longevity at the job
- county interagency group meetings monthly
- state coalition meetings. Agencies invited to present staff updates resources
- in-tact, conferences, phone contacts, county contacts, mail
- Meet with local agencies- have agency updates at our unit meetings
- In-services
- yearly- different agencies update us, new services send "info and procedures"
- I worked for home care and hospice for 2 ½ years. That's been extremely helpful. Also working in this region and doing discharge planning and social work in the hospital has been an education in itself… experience.
- In-service provided by county social services
- We do have different agencies come to our department meetings and talk
- Met with several staff of community resources

Question 13. b) If NO, what kind of training would you like to get?

- available continuum of care services in my region
- All training/new information is beneficial?
- can't think of anything
- criteria for eligibility for certain programs i.e.: SSD, MA, spousal program, ND legal aid
- I feel informed

Question 15. Do you feel like there are enough choices of continuum of care services available for the elderly and people with disabilities in your community? If NO, what services do you think are needed in your community?

- They want something between extended care and SNE that is low cost or free and allows them to stay out of the SNE
- Adult day care, more assisted living
- Those that don't need skilled care- nursing, patients, etc. but still need help at home, adult day care
- Adult day care, more hospice, homemakers, home health, personal care
- Financially unable to afford or staff all services that meet everyone's needs at times there is a need to leave our communities
- Weekend services, weekend night transportation services that can cross county lines
- Adult day care
- 24 hour home care
- daily transportation; (we have weekly only) assisted living facility

- Homemaker services for assisted and daily living (ADL) in home is very limited
- All services marked "NO" for # 14
- Services that extend into the rural area and into the smaller communities
- Housing that is affordable
- more basic care beds and NH beds in area
- apartments for handicap or elderly
- 1)adult day care 2)more transportation-individual 3) more assistance of Medicare 4)more medication administration and care management 5) more of almost everything in the rural areas for service
- the choices are there but restrictions prevent many from utilizing them
- very limited resources for severe mental health issues
- Caregivers- accessible and cost effective more handicapped housing
- Transportation for elderly to social events in the evening and weekends
- foster care, assisted living

Question 16. If consumers and family members were able to go to one place to access information about continuum of care services available in the community (a single point of entry), describe what it should it be like?

- I really don't know
- Hospital LSW
- Very informative, pamphlets/informational handouts
- Very user friendly and easy to access and understand fully understand, explain services and costs upfront
- I think it would be a place for all consumers youth adults and elderly towns offer many services and activities that most people do not know of them
- A neutral entity that could represent all facets available
- a section of the senior center in each community
- one building central intake worker who identifies all services they are eligible for
- community- wide social services office
- Available at least 5 days per week. With phone contact if off hrs. need should arise- rural areas would be beneficial if a representation would be available to go into the home
- senior services outreach offers info on every service available to elderly and people with disabilities
- meeting an outreach worker who can evaluate needs and give consumer/family members info. I believe the personal contact is best. Having a resource book available is easy to read
- easy access- telephone with no 'push to get…, push 2 for…' someone answers at ring
- 1)someone you can call who will give you answers IE information and direction 2)at time a phone call set up an appointment to meet with family, patient in the office and in patients home if necessary or a more complete evaluation is called for
- provide pamphlets be manned by knowledgeable staff sensitive to the needs of the elderly/disabled
- hospital or senior center or county social worker would provide info and referral upon request

- call center hotline, information and referral data at the public library is a great resource
- our senior citizens center
- not sure

Question 17. Where should this single point of entry be? (please describe)

- not sure
- hospital
- city court house- social service department
- initial meeting at patient, residents, clients "our intake conference"
- social services maybe, the hospital would be another choice
- Almost everyone goes to the grocery store- a building close by would be ideal. Needs to be close to main places that are frequented daily
- social services agency
- Neutral easily accessible
- location not as important as the need to be easy to find. Convenient parking
- as above (above: community wide social services office)
- many of our elderly would be more at ease and possibly would be more accepting if the contracts were not out of their comfort zone- I realize these services are difficult to provide
- it seems to work well to contact Out Reach Services- they will come to a person's home to visit with them
- senior center or social services
- senior centers
- ? senior center
- in each county at least better yet in each rural town. It should be a state agency. Especially in our very rural ND. We have so many elderly- frail elderly and so few young people and extended family members. The aging of our rural communities: blend the exodus of young people for work has destroyed our elderly support system
- Hospital, clinic, senior center
- hospital or county social services
- commission on aging services- Human Service Center - the library office
- senior citizens center. I would suggest adding some staff hours per week
- not sure

Question 18. What should the single point of entry to continuum of care services have available? (check all that apply) Other section:

- Family support and guidance
- events and activities information, transportation information
- staff
- Something that is available for all elderly; the eligibility requirement prevent many "functioning" elderly from getting the services they need. Maybe if they would provide REAL services to patients often discharged. More options like adult day care and transportation
- Names, address and phone #'s of who to call
- resources available in the community, assistance with housing

Question 19. a) Would a single point of entry system be helpful to you in discharge planning? If YES, why would it be helpful for you?

- don't have to send families to many different places
- it would be a place where professionals and families could access information easily instead of wasting time waiting to contact the appropriate person in the appropriate agency (eliminate some "red tape")
- because all resources would be available or known right from the start; maybe avoid a lot of re-admits
- I would have one resource to refer people to that would cover all aspects during their time of transition/crisis
- Writing in a rural hosp serving several towns I don't know what is available in all towns. Some have service some do not
- Assess to staff knowledgeable in all aspects of service
- simplify my job
- I may be able to access services from another community which are not familiar to me
- convenience for patient; provide all resource information
- would probably be quite time-saving
- time saving- less confusion for patient/ family
- it would save time of making many phone calls
- once patient leaves hospital we no longer follow
- It would require only one call
- It would entail less telephone work and we would only have to give information once
- call one place instead of several to set up services at home
- could give a one-stop resource

Question 19. b) Would a single point of entry system be helpful to you in discharge planning? If NO, why would it not be helpful for you?

- We have a very effective system in place at d/c planning. We have an assessment team in place. Each persons needs are different so one system will not meet all needs
- We really need more basic care and assisted living facilities that are affordable. It would be helpful to patients and families needing additional services, that would key them safe and functionary well in their homes.
- If needs exist upon discharge, these need to be addressed so the transition between hospital/skilled care home or other setting is as seamless as possible. This reassures that referrals are made prior to discharge. One could refer the patient/family to the point of entry to peruse the information and decide for themselves what they need when they are able to get there (after they have recovered)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